

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fallston (rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fallston (rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Wells</u>	(Middle) <u>L.</u>	(Last) <u>Blevins</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 4, 1873</u>
9. AGE last birthday <u>78</u> yrs.		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>1</u> (Year) <u>1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>N.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>George W. Blevins</u>	
14. MOTHER'S MAIDEN NAME <u>Cynthia Baker</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY No. <u></u>		17. INFORMANT AND ADDRESS <u>Mrs. Minnie Ann Blevins, Fallston P.D.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH <u>md</u>
Immediate cause (a) <u>Carcinoma of Liver prob. metastatic</u>			<u>3 years</u>
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c) <u>Source unknown</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5/26/51</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/1/1948</u> , to <u>5/26/1951</u> , that I last saw the deceased alive on <u>5/26/1951</u> , and that death occurred at <u>1</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>Robert Barthel MD</u>		ADDRESS <u>Forest Hill, Maryland.</u>	
DATE SIGNED <u>June 2, 1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>June 3, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Bell Air Memorial Gardens</u>		LOCATION (City, town, or county) <u>Bell Air, Harford Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Martin G. Kurtz, Jarrettsville, Md.</u>		ADDRESS <u></u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JUN 7 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06018

Reg. Dist. No. 1823

1. PLACE OF DEATH - COUNTY <u>Harford</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>md</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sancti Spiritus</u>		LENGTH OF STAY (in this place) <u>2 1/2 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sancti Spiritus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Jacob</u>	(Middle) <u>Andrew</u>	(Last) <u>Baker</u>	4. DATE OF DEATH	(Month) <u>June</u> (Day) <u>7</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan 22 - 1964</u>	9. AGE last birthday <u>87</u> yrs.	If under 1 year Months <u>4</u> Days <u>16</u> If under 24 hrs. Hours <u>16</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farming Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm crops</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Harford Co</u>	
13. FATHER'S NAME <u>Anthony Baker</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Barber</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>-</u>		17. INFORMANT AND ADDRESS <u>Mrs Edna Taylor Sancti Spiritus md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Senility -

177X Antecedent cause(s) -
 Diseases or conditions, if any,
 giving rise to the above cause
 stating the underlying cause last

(b) Carcinoma of Prostate Gland -(c) Atherosclerosis, general

INTERVAL BETWEEN ONSET AND DEATH

1944-51

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
 related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 1948, to June 7, 1951, that I last saw the deceased alive on 6/7/51, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>June 9 - 1951</u>	<u>Bethel</u>	<u>Maryland Harford md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6/8/51</u>	<u>Priscilla Lowwood</u>	<u>Marion E. Kuntz</u>	<u>Sancti Spiritus md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06019

Reg. Dist. No. 182

1. PLACE OF DEATH- COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE OHIO COUNTY - -	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CONOWINGO		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN MEDINA	
HOSPITAL OR INSTITUTION OR STREET ADDRESS CONOWINGO DAM		STREET ADDRESS (If rural give location) Route # 5	
3. NAME OF DECEASED (First) DONALD HAROLD (Middle) (Last) BURKEY	4. DATE OF DEATH (Month) JUNE (Day) 17 (Year) 1951		
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH 2 Jan 1930
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY	9. AGE last birthday 21 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) MEDINA, OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ARTHUR J. BURKEY		14. MOTHER'S MAIDEN NAME ELIZABETH BURKEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If year, give year or dates of service) PRESENT		16. SOCIAL SECURITY No. ASN: US52146225	
17. INFORMANT Records, Army Chemical Center, Md.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Accidental Drowning					
Antecedent cause(s) (b) 929.8					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 183					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) Accident		PLACE (Home, farm, factory, street, OF office hldg., etc.) Conowingo Dam		(CITY OR TOWN) CONOWINGO (COUNTY) HARFORD (STATE) MARYLAND	
TIME (Month) (Day) (Year) (Hour) OF INJURY JUNE 17 1951 7Pm.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? While swimming	

22. I hereby certify that I attended the deceased from **XXXXXX** to **XXXXXX** and that death occurred at **7:00 P.m.**, from the causes and on the date stated above.

SIGNATURE Leon A. P. Stein (Degree or title) Major, MC, Post Surgeon, Army Chemical Center, Md.		DATE SIGNED 18 June 1951	
23. BURIAL, CREMATION, REMOVAL (Specify) Removal DATE June 19, 1951		NAME OF CEMETERY OR CREMATORY Kindig Funeral Home LOCATION (City, town, or county) Seville (State) Ohio	
DATE REC'D BY LOCAL REG. June 23, 1951 REGISTRAR'S SIGNATURE C. W. Kirk		24. FUNERAL DIRECTOR Howard H. McCombs ADDRESS At home Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 28 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06020

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH- COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> <u>Harford</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Havre de Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Havre de Grace</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Francis Villa</u>		STREET ADDRESS (If rural, give location) <u>Commerce & Market</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Siater Mary Ehrentrude (Laura Cope)</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6/16/51</u> <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3/14/1870</u>
9. AGE last birthday <u>81</u> yrs.		10. If under 1 year 1 year If under 24 hrs. Months Days Hours Min. <u>3</u> <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Catholic School</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Cope</u>		14. MOTHER'S MAIDEN NAME <u>Ellen T. O'Dea</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Hosp. Records, Havre de Grace, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Carcinoma Rt. Breast</u>		<u>5 yrs</u>
Antecedent cause(s) (b) <u>Mammary gland</u>		<u>1 yr</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>General Carcinomatosis</u>		<u>3 mos</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 1946, to June 1951, that I last saw the deceased alive on June 16, 1951, and that death occurred at 8 P.M., from the causes and on the date stated above.

SIGNATURE Charles Henry M.D. DATE SIGNED June 18/51
(Degree or title) ADDRESS 400 S. Main Ave. Havre de Grace Md.

23. BURIAL, CREMATION, REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
Burial 6/19/51 Holy Redeemer Baltimore, Md.

DATE REC'D BY LOCAL REG. June 18-1951 REGISTRAR'S SIGNATURE G. L. Lewis M.D. 24. FUNERAL DIRECTOR ADDRESS Wilmington & Son, Havre de Grace, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

093896

RECEIVED
JUN 21 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH- COUNTY <u>Hanover</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Hanover</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
TOWN <u>Bel Air</u>		TOWN <u>Bel Air</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u> (Middle) <u>White</u> (Last) <u>Leipert</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 25</u> <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov 23/1859</u>
9. AGE last birthday <u>97</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Seneca Lake NY</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Thomas Dobson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Fisher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>✓</u>	
17. INFORMANT AND ADDRESS <u>Mrs. E. C. Gann Joppa Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Hemorrhage

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceasedalive on Dead on arrival, 1957, and that death occurred at 1:48 P m., from the causes and on the date stated above.SIGNATURE Charles Richardson, M.D. ADDRESS Bel Air, Md DATE SIGNED 6/26/57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>June 26-57</u>	NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	LOCATION (City, town, or county) <u>Baltimore Md</u>	(State)
DATE REC'D BY LOCAL REG <u>6/25/57</u>	REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>	24. FUNERAL DIRECTOR <u>Joseph J Foster</u>	ADDRESS <u>Bel Air Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 28 1961
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

06022

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <i>Hartford</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>MD</i> COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Sharon</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Essey Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <i>1620 Doolittle Rd</i>	
3. NAME OF DECEASED (Type or Print) <i>Thomas Clyde Devore</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>June 16 1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>June 27/1924</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Observer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Steel Works</i>	9. AGE last birthday <i>26</i> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Cottleville Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Wm C Devore</i>		14. MOTHER'S MAIDEN NAME <i>Isabelle J Caldwell</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>World War 2</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Wm C Devore</i>		18. ADDRESS <i>2908 Richmond Ave Baltimore (19)</i>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

802.8 Immediate cause

(a) *Fracture of spine*

Antecedent cause(s)
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

169

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

Fracture of humerus, tibia & fibula

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY *Sharon Station, Ford Hill, Hartford, Md*

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY *June 16, 1951 4:25 p.m.*

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

On trestle & hit by train

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Gerald C. P. Jones, M.D. Deputy Medical Examiner

Hartford County, Bel Air, Md 6/16/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/18/51

A. W. Hedrick

Ulrich Funeral Home 2112 Dundalk Ave

NT

690 326

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06023

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Haute de Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Belcamp, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Mem. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>Pulaski Highway</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Joseph</u>	(Middle) <u>Frank</u>	(Last) <u>Dudek</u>
4. DATE OF DEATH	(Month) <u>6</u>	(Day) <u>8</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>3-23-78</u>
9. AGE last birthday <u>73</u> yrs.		10. If under 1 year: Months <u>2</u> Days <u>13</u> Hours <u></u> Min. <u></u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
12. BIRTHPLACE (State or foreign country) <u>Maryland</u>		13. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
14. FATHER'S NAME <u>Joseph Dudek</u>		15. MOTHER'S MAIDEN NAME <u>Barbara ?</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		17. SOCIAL SECURITY NO. <u>Unknown</u>	
18. INFORMANT AND ADDRESS <u>Mr. Chas. Hendricks, Stepney, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) arteriosclerotic Cardiovascular

Antecedent cause(s)

(b) renal disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 30, 1951, to June 8, 1951, that I last saw the deceased alive on June 8, 1951, and that death occurred at 8:55 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/11/51</u>	<u>Holy Redeemer</u>	<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS	
<u>June 10 - 1951</u>	<u>G. L. Lewis M.D.</u>	<u>Funeral Home, Haute de Grace</u>		

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *182*

1. PLACE OF DEATH: COUNTY <i>Hartford</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>MD</i> COUNTY <i>Hartford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Kelmdia</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
TOWN <i>Kelmdia</i>		TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Walters Nursing Home</i>		STREET ADDRESS (If rural, give location) <i>✓</i>	
3. NAME OF DECEASED (Type or Print) (First) <i>Clara</i> (Middle) <i>K</i> (Last) <i>FAMOUS</i>		4. DATE OF DEATH (Month) <i>June</i> (Day) <i>21</i> (Year) <i>1951</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>about 1890</i>
9. AGE last birthday <i>81</i> yrs.		10. If under 1 year: Months <i>8</i> Days <i>21</i> Hours <i>19</i> Mins. <i>51</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>	
13. FATHER'S NAME <i>James Morgan</i>		14. MOTHER'S MAIDEN NAME <i>Mary Holland</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY No. <i>none</i>	
17. INFORMANT AND ADDRESS <i>Milford R Morgan Bel Air RD 2 Md</i>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *CEREBRAL EMBOLISM*

INTERVAL BETWEEN ONSET AND DEATH *2 da*

Antecedent cause(s)

(b) *Chr. Cardio-Vascular disease*

3 yr.

(c) *422.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d*

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *May 2, 1949*, to *June 26, 1951*, that I last saw the deceased alive on *June 20, 1951*, and that death occurred at *2:30 a.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Willard P. Hudson, M.D. Forest Hill Md 6/21/51
Burial June 23/51 Parkwood Baltimore MD
6/22/51 Lucille Louwood Joseph J. Foster Bel Air Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A1P

RECEIVED
JUN 26 1961
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06025 181

1. PLACE OF DEATH- COUNTY Harford MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Kansas COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Aberdeen		CITY (If outside corporate limits, write RURAL and give nearest town) Witchita	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2151-1 US Army Hospital Aberdeen Proving Ground		STREET ADDRESS (If rural, give location) 151 North Charles St	
3. NAME OF DECEASED (Type or Print)	(First) Elmer	(Middle) L.	(Last) Heibert
4. DATE OF DEATH	(Month) June	(Day) 2	(Year) 19 51
5. SEX Male	6. COLOR OR RACE White	7. STATUS OF MARRIAGE DIVORCED (Specify)	8. DATE OF BIRTH 30 April 1929
9. AGE last birthday 22 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Jacob K. Heibert		14. MOTHER'S MAIDEN NAME Martha Sara -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY No. Unknown	
(If yes, give war or dates of service) Current		17. INFORMANT AND ADDRESS Service Record	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Subdural Hematoma

INTERVAL BETWEEN ONSET AND DEATH

20 min

825.5

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause

1700

stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐21. ACCIDENT ☒ (Specify) SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY 40

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY June 2 1951 m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

Auto Accident

22. I hereby certify that I attended the deceased from June 2, 1951, to June 2, 1951, that I last saw the deceased

alive on June 2, 1951, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Abingdon Md 395916

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V.S.S.

JUN 13 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

06026

1. PLACE OF DEATH: COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Upper Cross Rds.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Upper Cross Rds.</u>	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Thomas</u> (First) <u>Jefferson</u> (Middle) <u>Hitchcock</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>24</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 14, 1862</u>
9. AGE last birthday <u>89</u> yrs.		10. If under 1 year: Months <u>1</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - dairy</u>		10b. Kind of BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Bennett Hitchcock</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Chemworth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Mr. Leslie Bachman - Upper Cross Rds. Md.</u>	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Congestive Heart Failure

INTERVAL BETWEEN ONSET AND DEATH

4 Mos.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Arteriosclerotic Heart Disease9 yrs.General Arteriosclerosis15 yrs.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Hypertrophic Arthritis16 yrs.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 8, 1935, to June 24, 1957, that I last saw the deceasedalive on June 23, 1957, and that death occurred at 1:2 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 27, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Provident Cem</u>	LOCATION (City, town, or county) <u>Harford Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>6/26/57</u>	REGISTRAR'S SIGNATURE <u>Praxilla Howard</u>	24. FUNERAL DIRECTOR <u>H. S. Bailey</u>	ADDRESS <u>Wilmington</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AT5

RECEIVED
JUN 28 1961
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06027 185-
Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Havre de Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Havre de Grace</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>721 Otsego St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Harry</u>	(Middle)	(Last) <u>Jones</u>
4. DATE OF DEATH	(Month) <u>6</u>	(Day) <u>27</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-12-71</u>
9. AGE last birthday <u>79</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dept. Store Salesman</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Allen Jones</u>	14. MOTHER'S MAIDEN NAME <u>Caroline Roe</u>	15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>
16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <u>Mr. Donald H. Jones</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Heart Failure
(b) Chronic Myocarditis
(c) Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6-27, 1951, to 6-27, 1951, that I last saw the deceased

alive on 6-27, 1951 and that death occurred at 4:45 P.M. from the causes and on the date stated above.

SIGNATURE G. L. Lewis M.D. (Degree or title) ADDRESS Same as above DATE SIGNED 6-28-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6-30-51</u>	<u>Angel Hill Cem.</u>	<u>Havre de Grace, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>June 28-1951</u>	<u>G. L. Lewis M.D.</u>	<u>W. Madison Mitchell</u>	<u>Havre de Grace Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 180-

06028

1. PLACE OF DEATH- COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAURE DE GRACE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BELAIR</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>NARUEL</u>	(Middle) <u>COLBURN</u>	(Last) <u>LEWIS</u>
4. DATE OF DEATH	(Month) <u>JUNE</u>	(Day) <u>17</u>	(Year) <u>1951</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>SEPT. 8, 1946</u>
9. AGE last birthday <u>4</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES RUMSEY</u>		14. MOTHER'S MAIDEN NAME <u>ROSA E. LEWIS</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Peritonitis

550.1 Antecedent cause(s) (b) Ruptured appendix

121 Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

36 hrs

?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from JUNE 15, 1951, to JUNE 17, 1951, that I last saw the deceased alive on JUNE 17, 1951, and that death occurred at 3:15 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>June 20, 1951</u>	<u>Clark's Chapel Cn.</u>	<u>Harford Co. Md.</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>June 17-1951</u>	<u>G. L. Lewis M.D.</u>	<u>H. S. Bailey</u>	<u>Wilmington, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H. B. Lee

RECEIVED
JUN 19 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06029 181

1. PLACE OF DEATH COUNTY Harford MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Wisconsin COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Aberdeen		CITY (If outside corporate limits, write RURAL and give nearest town) Milwaukee	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2151-1 US Army Hospital Aberdeen PrGr		STREET ADDRESS (If rural, give location) 111 South 6th Street	
3. NAME OF DECEASED (First) PHILIP (Middle) A. (Last) MATEL		4. DATE OF DEATH (Month) June (Day) 2 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED Single (Specify)	8. DATE OF BIRTH 21 June 1928
9. AGE last birthday 22 yrs.		10. CITIZEN OF WHAT COUNTRY? US	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Felix Matel		14. MOTHER'S MAIDEN NAME Helen - unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) Current		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS Service Record			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Ruptured liver			
Antecedent cause(s) (b) 825.5 1202			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture of skull through sagittal sinus			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
	No operation		
21. ACCIDENT (Specify) SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) INJURY	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	(CITY OR TOWN) near Edgewood Intersection, Md.	(COUNTY) Prince Georges
June 2 51	accident	accident	accident
22. I hereby certify that I attended the deceased from June 2 51 , 19 51 , to June 2 51 , 19 51 , that I last saw the deceased alive on June 2 51 , 19 51 , and that death occurred at US Army Hospital 4 PG, Md , from the causes and on the date stated above.			
SIGNATURE Don L. Lynch		DATE SIGNED 2 June 51	
23. BURIAL, CREMATION, REMOVAL (Specify) Removal		LOCATION (City, town, or county) (State) Milwaukee Wis.	
DATE REC'D BY LOCAL REG. June 12 51		24. FUNERAL DIRECTOR Howard R. McCreary ADDRESS Arlington Maryland 51346	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 13 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06030

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH: COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>FEDERAL HILL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>FEDERAL HILL</u>	
TOWN <u>FEDERAL HILL</u>		TOWN <u>FEDERAL HILL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>STREET R. D.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LAWSON</u>	(Middle) <u>GARFIELD</u>	(Last) <u>MOORE</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>23</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6-14-1880</u>
9. AGE last birthday <u>71</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>
11. BIRTHPLACE (State or foreign country) <u>MADISON N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ISAAC F. MOORE</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET HOPPS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>218-10-1322</u>	
(If yes, give war or dates of service) <u>COAST GUARD</u>		17. INFORMANT AND ADDRESS <u>Andrew Moore Street Md.</u>	
<u>ARTIL</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>LOBAR PNEUMONIA</u>		<u>4da</u>	
Antecedent cause(s) (b) <u>Chn Hypertensive Cardio-Vascular disease ?</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>108</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
SUICIDE	INJURY		
HOMICIDE			
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
OF INJURY			
22. I hereby certify that I attended the deceased from <u>May 5</u> , 1951, to <u>June 23</u> , 1951, that I last saw the deceased alive on <u>June 23</u> , 1951, and that death occurred at <u>10:50</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>Willard P. Hudson, M.D.</u>		ADDRESS <u>Forest Hill Md</u>	
(Degree or title)		DATE SIGNED <u>6/23/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>6-26-51</u>	NAME OF CEMETERY OR CREMATORY <u>Sanctaville</u>	LOCATION (City, town, or county) (State) <u>Sanctaville Md</u>
DATE REC'D BY LOCAL REG. <u>6/25/51</u>	REGISTRAR'S SIGNATURE <u>W. H. H. Howard</u>	24. FUNERAL DIRECTOR <u>W. H. H. Howard</u>	
		ADDRESS <u>Sanctaville Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Susan</u> (Middle) <u>Calarie</u> (Last) <u>Poole</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>9th</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 12 - 1870</u>
9. AGE last birthday <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>P. L. Heckler</u>		14. MOTHER'S MAIDEN NAME <u>Phoebe E. Cornett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT AND ADDRESS <u>David T. Poole - Churchville Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Adenocarcinoma, common bile duct

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 year

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Arteriosclerotic C-V

eyes

19a. DATE OF OPERATION

Dec. 26 - 1950

19b. MAJOR FINDINGS OF OPERATION

Adenocarcinoma, common bile duct, histologically

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1950, to June, 1951, that I last saw the deceased

alive on June 9, 1951, and that death occurred at 10:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR OTHER DISPOSAL (Specify)

Burial

DATE THEREOF

June 12 - 1951

NAME OF CEMETERY OR CREMATORY

Churchville Cemetery

LOCATION (City, town, or county)

Churchville Maryland

(State)

REGISTRAR'S SIGNATURE

Nellie H. Riley

24. FUNERAL DIRECTOR

Henry Tarrington

ADDRESS

Sous afterden

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JUN 25 1961
BUREAU V. S.

Reg. Dist. No. 102

VS. A13A

RECEIVED
JUN 28 1961
BUREAU V. S.

DEATH & BIRTH 07134
~~BIRTH and DEATH~~

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 182

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Hartford.
City or town Rural - Street,
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital, or institution:
Rural Address
Length of mother's stay in County life
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
County Hartford.
City or town Rural - Street
(If outside city or town limits, write RURAL and give nearest town)
Street No. Nr. Highland
(If RURAL give LOCATION)

3. Name of child Unnamed.

5. Sex Male | 6. Twin or triplet 0

4. Date of birth 6-26-1951 Hour 6³⁰ A.M.

7. No. of weeks pregnancy 7 wks.

FATHER OF CHILD

8. Full name Charles Presbury
9. Color Col. 10. Age at time of this birth 24 yrs.
11. Usual occupation Army.

MOTHER OF CHILD

12. Full maiden name Dorothy Rice
13. Color Col. 14. Age at time of this birth 19 yrs.
15. Usual occupation Housework.

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of Premature delivery.

19. Labor: (a) Complications of None
(b) Induced?

20. (a) Was there an operation for delivery? No
(b) State all operations, if any None. (Yes or No)

(c) Did child die before operation? No
During operation? No.

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Atelectasis.

(b) Maternal causes None.

762.5
22. I certify to the birth of this child who was born dead* on the date and hour above stated.

159 Signature Charles A. Hoff MD.
(Specify if M. D., midwife, or other)

Address Street, Md.

23. (a) Burial. (b) Date thereof 6/29/51
(Burial, cremation or removal) (month/day/year)

(c) Cemetery or crematory Mont. of Faith

24. (a) Funeral director Charles Presbury (Father)
(b) Address Street, Md.

25. (a) 6-27-51 (b) P. H. Wood
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per.....

* See Instruction C on stub.

106261192 -V

CHILD LIVED 15 MIN.

V. S. A10

RECEIVED
JUN 28 1951
BUREAU OF
BUREAU OF
POSTAL SERVICE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06033

Reg. Dist. No. 181

1. PLACE OF DEATH- COUNTY Harford MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Vermont COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Aberdeen		CITY (If outside corporate limits, write RURAL and give nearest town) Burlington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2151-1 US Army Hospital Aberdeen Proving Ground		STREET ADDRESS (If rural, give location) 65 Central Avenue	
3. NAME OF DECEASED (Type or Print)	(First) RENE (Middle) J. (Last) RICHER	4. DATE OF DEATH	(Month) June (Day) 2 (Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 14 April 1926 25 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY US Army	11. BIRTHPLACE (State or foreign country) Vermont
13. FATHER'S NAME Emile Richer		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Current		17. INFORMANT AND ADDRESS xPx Service Records	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Depressed fracture of skull, right temporal		
Antecedent cause(s) (b) with extension through the base		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Rupture of liver		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY US Highway 134.40 near Edgewood intersection, Md.	
TIME (Month) (Day) (Year) (Hour) OF INJURY June 2 51 m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Automobile accident
22. I hereby certify that I attended the deceased from 1951, to 1951, that I last saw the deceased alive on 1951, and that death occurred at 1951, m., from the causes and on the date stated above.		
SIGNATURE (Degree or title) Donl. Lynch 1st MC		ADDRESS U.S. Army Hospital, APG, Md
DATE SIGNED 3 June 51		
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF June 4, 1951	NAME OF CEMETERY OR CREMATORY, LOCATION (City, town, or county) (State) Memorial Funeral Home Burlington, VT.
DATE REC'D BY LOCAL REG. June 12-51	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR'S ADDRESS Howard K. McCord & Son Abingdon Md 54596

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

RECEIVED
JUN 13 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

06034

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill Rural MD</u>	
TOWN <u>Forest Hill Rural</u>		TOWN <u>Forest Hill Rural MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>JOHN</u> (Middle) <u>W</u> (Last) <u>ROBINSON</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 1 1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Owner of some</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE last birthday <u>85</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Forest Hill MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Barnes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Maudie Robinson Forest Hill MD</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) LOBAR PNEUMONIA, Terminating

INTERVAL BETWEEN ONSET AND DEATH

48 hrs

Antecedent cause(s)

(b) Cachexia Caused by Epithelioma of EAR15 yrs.(c) stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1 -, 1950., to June 22, 1951., that I last saw the deceasedalive on June 21, 1951., and that death occurred at 2:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6/23/51Phyllis TowoodJoseph Foster Bellan MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. ATB

100105

RECEIVED
JUN 26 1967
BUREAU OF
F. A. I.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06035
180

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Florida</u> COUNTY <u>Palm Beach</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towpe</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>West Palm Beach</u>	
TOWN <u>Towpe</u>		TOWN <u>West Palm Beach</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allers Cabin Town</u>		STREET ADDRESS (If rural give location) <u>1510 S. Olive St</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Ida</u> (Middle) <u>M</u> (Last) <u>Stromberg</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>May 5 1881</u>	
9. AGE last birthday <u>69</u> yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Christian Parsons</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Anderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>F. H. Christianburg, W. Palm Beach Fla</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypertensive Cardiovascular Disease 1 year

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

443X
93dII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Gerald C Palmer M.D. Deputy Medical Examiner Harford Co Baltimore Md 6/16/51

23. BURIAL, CREMATION REMOVAL (Specify) Removal DATE THEREOF 6/16/51 NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery LOCATION (City, town, or county) West Palm Beach (State) Fla

DATE REC'D BY LOCAL REG 6/16/51 REGISTRAR'S SIGNATURE Maureen Monksaugh Henry 24. FUNERAL DIRECTOR. Tarryn & Son ADDRESS Aberdeen Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 18 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH- COUNTY <u>Harford</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace - Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp.</u>		STREET ADDRESS (If rural, give location) <u>Ontario St. Ext.</u>	
3. NAME OF DECEASED (Type or Print) <u>Bessie</u> (First) <u>S.</u> (Middle) <u>Taylor</u> (Last)		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>17</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 17, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>66</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Anna Courtney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>S. Howard Taylor (Husband) Same address</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Hemorrhage

Antecedent cause(s)

(b)

Hypertension

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Coma

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) (Min.)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6-15, 1957 to June 17, 1957, that I last saw the deceasedalive on June 17, 1957, and that death occurred at 8:15 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REINTERMENT (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>June 29, 1957</u>	<u>Rock Run Cem</u>	<u>Harford Co.</u>	<u>md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>June 18, 1957</u>	<u>G. L. Lewis M.D.</u>	<u>H. S. Bailey</u>	<u>Warrington md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06037

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Harre de Grace</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Conowingo</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial Hosp</i>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>Everett</i>	(Middle) <i>Clayton</i>	(Last) <i>Taylor</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>June 26 1951</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs. <i>6</i> Months <i>96</i> Days <i>519</i> Min.
11. BIRTHPLACE (State or foreign country) <i>United States of America</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Everett Clayton Taylor</i>		14. MOTHER'S MAIDEN NAME <i>L015 Jean Mae Cayley</i>	
15. WAS DECEASED EVER IN U.S./ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <i>mother</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776X Immediate cause (a) *Respiratory Failure*
Antecedent cause(s) (b) *Pneumonia*
159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH
7 hrs.
7 months

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *6-26*, 19*51*, to *6-26*, 19*51*, that I last saw the deceased alive on *6-26*, 19*51*, and that death occurred at *5:50 P.m.*, from the causes and on the date stated above.

SIGNATURE *Daniel D. Dolce M.D.* ADDRESS *Harre de Grace, Md.* DATE SIGNED *6/26/51*
(Degree or title)

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>General</i>	<i>June 27 1951</i>	<i>West Goshenham</i>	<i>Coleman</i>	<i>Cecil Md.</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>June 26-1951</i>	<i>A. L. Lewis M.D.</i>	<i>J. G. Tyson</i>	<i>Piary Sun Md.</i>	

206261171302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06038 182

1. PLACE OF DEATH: COUNTY <u>Hartford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bell Air Rural</u> TOWN <u>Bell Air Rural</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Hartford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bell Air Rural</u> TOWN <u>Bell Air Rural</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>JACOB</u> (Middle) <u>Livagey</u> (Last) <u>TERRY</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec 28 / 1865</u> 9. AGE last birthday <u>85</u> years
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Hartford Co</u>
13. FATHER'S NAME <u>Joseph R Terry</u>		14. MOTHER'S MAIDEN NAME <u>Edith Livagey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT AND ADDRESS <u>Mrs J Herbert Hanna Bell Air Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CEREBRAL HEMORRHAGE

422.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) CEREBRAL ARTERIO-SCLEROSIS(c) Chr. Myocardial Disease

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Generalized Arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1945, to June 27 1951, that I last saw the deceased alive on June 27, 1951, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

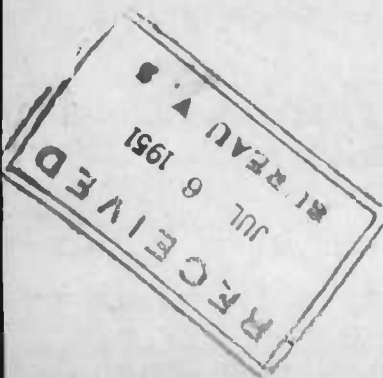
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 30 / 51</u>	NAME OF CEMETERY OR CREMATORY <u>Friendship</u>	LOCATION (City, town, or county) <u>Fallston (Rural)</u> (State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>6/29/51</u>	REGISTRAR'S SIGNATURE <u>Willa Louwood</u>	24. FUNERAL DIRECTOR <u>Joseph J Foster, Bell Air, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

501817



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH- COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Hart</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hurdman</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S.A.H. APT. MD</u>		STREET ADDRESS (If rural, give location) <u>Bldg #5 Apt. A Jacob Street</u>	
3. NAME OF DECEASED (Type or Print) <u>DIANA</u> (First) <u>LISA</u> (Middle) <u>Vaughn</u> (Last)		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>6</u> (Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>5 June 51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Michael Vaughn</u>		14. MOTHER'S MAIDEN NAME <u>Christine Goodman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Christine Goodman</u>

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Prima facie

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5 June, 1957, to 6 June, 1957, that I last saw the deceasedalive on 5 June, 1957, and that death occurred at 8:25 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF 6/8/57NAME OF CEMETERY OR CREMATORY Post CemeteryLOCATION (City, town, or county) Army Chemical Center, Md

(State)

DATE REC'D BY LOCAL REG. June 7-57REGISTRAR'S SIGNATURE William H. Riley24. FUNERAL DIRECTOR Elmer E. Bullock - Hurdman, Md

ADDRESS

20651222260

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-1A15

RECEIVED
JUN 13 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

06040

1. PLACE OF DEATH - COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cylissville</u>	
TOWN <u>White Hall</u>		TOWN <u>Cylissville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Robert</u> (Middle) <u>L</u> (Last) <u>Walter</u>		(Month) <u>June</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 3 1874</u>
9. AGE last birthday <u>77</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Theodore Walter</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hornum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>2-8 2</u>	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. Robert L. Hornum 2411 N. Charles St.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pulmonary Edema</u>		18. MEDICAL CERTIFICATION	
Antecedent cause(s) (b) <u>Carcinoma, Prostate gland</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>generalized adenoma & pulmonary metastases</u>			
II. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
SUICIDE	HOMICIDE		
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?	
OF	While at Not While		
INJURY	m. Work <input type="checkbox"/> At work <input type="checkbox"/>		

22. I hereby certify that I attended the deceased from Augt., 1950, to June 14, 1951, that I last saw the deceased alive on June 15, 1951, and that death occurred at 5 P.M., from the causes and on the date stated above.

SIGNATURE <u>J. M. Hornum Jr.</u>	(Degree or title)	ADDRESS <u>2411 N. Charles St.</u>	DATE SIGNED <u>6/16/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>June 17, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Highland</u>	LOCATION (City, town, or county) <u>Street</u> (State) <u>Md</u>
DATE REG'D BY LOCAL REG. <u>6/16/51</u>	REGISTRAR'S SIGNATURE <u>Marcella Fourwood</u>	24. FUNERAL DIRECTOR <u>Marcella Fourwood</u>	ADDRESS <u>2411 N. Charles St.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

290506

RECEIVED
JUN 19 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

06041

1. PLACE OF DEATH- COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Perryman, Md.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace, Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>618 Concord Street</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>John</i>	(Middle) <i>H.</i>	(Last) <i>Welsh</i>
4. SEX <i>Male</i>	5. COLOR OR RACE <i>Negro</i>	6. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	7. DATE OF BIRTH <i>Mar. 29, 1866</i>
8. AGE last birthday <i>85</i> yrs.	9. DATE OF DEATH <i>6</i> (Month) <i>19</i> (Day) <i>1951</i> (Year)	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fisherman</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Fisherman</i>
11. BIRTHPLACE (State or foreign country) <i>Edgewood, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>Garrett Welsh</i>	14. MOTHER'S MAIDEN NAME <i>Harriett ?</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <i>Mrs. Hattie Christy, Perryman, Md.</i>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Cerebral Thrombosis*

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) *Arteriosclerotic Heart Disease*

(c)

INTERVAL BETWEEN ONSET AND DEATH

*2 hrs.**15 yrs.*11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *12/1*, 1950, to *6/19*, 1951, that I last saw the deceasedalive on *6/19*, 1951, and that death occurred at *11:20 p.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>6/23/51</i>	NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cemetery</i>	LOCATION (City, town, or county) <i>Abertown, Md.</i>	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR <i>Elmer E. Bullock</i>	ADDRESS <i>Havre de Grace, Md.</i>	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

910126

RECEIVED
JUN 25 1964
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06469

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 185

1. PLACE OF DEATH- COUNTY <u>Harford</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Ad.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		LENGTH OF STAY (in this place) <u>2 hours</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural, give location) <u>Unknown</u>	
3. NAME OF DECEASED (Type or Print) <u>Gleenn W. Ford</u>		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>June 21 1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>4/5/1905</u>	9. AGE last birthday <u>46</u> yrs.	If under 1 year Months <u>2</u> Days <u>16</u> Hours <u>16</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Airy</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>215-12-1065</u>		17. INFORMANT <u>Gleenn W. Whittington Annapolis Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

812.5

Immediate cause

(a)

Fracture skull

INTERVAL BETWEEN ONSET AND DEATH

2 hours

1700

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Fracture L. femur2 hrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY U.S. Route 40

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY June 21, 1951 7 P.m.INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

auto accid Auto Pedestrian type22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Leah C Palmer M.D. Deputy Medical Examiner Harford Co. Bel Air Md. 6/22/51

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 24 1951 A. L. Lewis M.D. Conyngham & Son, Harford Co. Md.

150105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED

JUN 27 1951

BUREAU V. S.